MEDISEC ON CALL

Winter 2016

Around the clock support for the Irish GP community

MEDISEC
IRELAND

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winter issue 2016

Deirdre McCarthy, In-house Legal Counsel is Editor of Medisec On Call. If there is anything you would like to see included in our newsletter, you can email Deirdre at deirdremccarthy@medisec.ie

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It's hard to believe that I am writing my fourth Christmas message. The last few years have flown by and 2016 will certainly go down as a very exciting year for Medisec as it marked the move into our new home at 7 Hatch Street Lower, Dublin 2. We have already welcomed a number of you and your practice staff to meetings in our beautiful new building, and as our educational and risk programmes expand, we hope to see many more of you over the years to come.

As with any year in the medico-legal arena, 2016 has brought many challenges. We have helped over 87 members with on-going medical negligence claims, approximately 55 members with new Medical Council complaints, and answered general medico-legal queries from over 1,000 members. New queries land on your desk every day. They can include dealing with requests from third parties to release medical records, medication errors, systems failures, and those queries which cover the span of a patient's journey through your practice; from infant guardianship issues, right through to end-of-life decision-making capacity. In assisting members on a 24/7 basis, our team provides expert advice with empathy and support so that while you deal with your patients, our focus is to look after and support you.

Over the past number of months, my colleagues and I have also met with, and provided risk and education training to as many members and GP trainees as possible; mainly through the Trainee Schemes at ICGP, Faculty Meetings and Conferences, and at specialised regional meetings and events. Throughout our travels we have been impressed with the commitment and breadth of expertise within the GP community and the passion and willingness of members to dedicate their time and energy to support patient care, often in difficult and trying circumstances.

In the run up to Christmas, I would like to thank the people that make our service possible. This includes you, our members, for the courtesy and loyalty shown to us over the years. It extends to our dedicated and committed staff for the energy, empathy and support displayed to members on a daily basis. It also includes our Board, friends of Medisec, stakeholders including the Medical Council, ICGP, HSE, SCA, HIQA, IMO and NAGP, who we have worked closely with over the last year with the shared goal of supporting GPs while enhancing patient care in Ireland.

On behalf of myself, and the entire Medisec team, we wish you a very Happy Christmas and every good wish for 2017.

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REPEAT PRESCRIBING

A BRIEF GUIDE TO BEST PRACTICE

by Walter Cullen, Professor of Urban General Practice, School of Medicine UCD and Medisec GP Advisory Panel Member

Repeat prescribing is an integral part of general practice and typically involves all members of the practice team. It is also a common source of medico-legal complaints. In fact problems arising from repeat prescribing account for 18% of requests for advice or assistance we receive in Medisec. As a result, the GP Advisory Panel has reviewed current guidelines on repeat prescribing to develop a brief guide for our members.

The guide highlights that all practices should have a formal policy on repeat prescribing, which should be communicated to all members of the practice team and shared with other stakeholders. Recognising that repeat prescribing policies may become more complicated, with increasing size and complexity of practices, the guide highlights the key areas which a 'Practice Policy on Repeat Prescribing' might address.

AUTHORISATION

Authorising a repeat prescription should ideally be undertaken face-to-face by a doctor who is familiar with the patient. At this consultation, the prescribing doctor should discuss with the patient that an ongoing prescription for the medicine is necessary, and ensure that the medicine is tolerated, not contraindicated and does not interact with other medicines. Based on issues such as age, cognitive function, polypharmacy, multi-morbidity, compliance, etc., the doctor should determine the frequency with which the patient should be reviewed.

MANAGEMENT OF PRESCRIPTION REQUESTS

Particular care is required when handling a request for a repeat prescription that does not involve a face-to-face consultation. When handling such requests, the practice should ascertain the:

- Name of person making the request;
- Relationship to patient;
- Name, address and date of birth of the patient;
- Medicines requested, including dose and frequency;
- Number of months the prescription is required for.

CHECKING

While non-medical members of the practice team may generate a repeat prescription, the GP is responsible for any issues arising from the prescription itself. While the prescription is being generated, a number of checks should be carried out, e.g.:

- Is the medication list an accurate reflection of the medicines that have been authorised by the practice for repeat prescribing?
- Is there evidence of non-adherence?
- Has the patient's medical history changed so that the medication's side effects or contraindications may be a problem?
- Have interventions from secondary care or other healthcare professionals altered medication needs?

APPROVAL & SIGNING

When writing or printing a prescription, the doctor should ensure that the prescription is legible, dated, signed and includes the IMC registration number. Prior to signing, the GP should also carry out a number of checks, including:

- Is there evidence of any prescribing errors?
- Are any interactions, contraindications, etc.?
- Is there a need for the patient to attend for review?
- Should the prescription be hand-written, e.g. in the case of controlled drugs?

THE REVIEW

All patients receiving long-term medicines should be regularly reviewed, with the interval between reviews determined by the GP or practice, varying on a case-by-case basis. The reviews might include these considerations:

- The medical problems for which medications are being prescribed;
- Medication dose, frequency, efficacy, tolerability, interactions, contraindications;
- Any investigations needed;
- Patient ideas, concerns.

The repeat prescribing-related issues that are most frequently reported by Medisec members are:

- The need for more care in prescribing practices (e.g. protected time for repeat prescribing);
- Failure to properly monitor medication dosage;
- Medication reconciliation especially with hospital, community or consultant interface;
- Proper monitoring of patient and issuing repeat prescriptions;
- Secretarial transcriptions and errors due to computer 'drop-down' menus;
- Mis-prescribing or over-prescribing of benzodiazepines;
- Appropriate training to prescribe Methadone.

Finally, the practice policy on repeat prescribing should include a method for incident reporting and recording and be subject to regular audit and quality review.

A full copy of the guide is available at medisec.ie

RECORDING OF CONSULTATIONS

WHEN IT COMES TO PATIENTS RECORDING MEDICAL CONSULTATIONS, WHERE DO GPS STAND?

The increased prevalence of smartphones has made it easy and indeed tempting for patients to record medical consultations and Medisec has advised an increasing number of concerned GPs in relation to the recording of consultations, whether covertly or with permission.

Understandably, some doctors would prefer not to be recorded during consultations and others feel that it is a complete breach of patient trust to be secretly recorded. So where do GPs stand?

Currently, there is no definitive legislation that covers the recording of private conversations between two individuals.

DATA PROTECTION LEGISLATION

S.4 of the Data Protection Act states that the Acts do not apply to:

"Personal data kept by an individual and concerned only with the management of his personal, family or household affairs or kept by an individual only for recreational purposes."

Therefore, in circumstances where the recording is made for an individual's private purpose, such as an aide-memoire of the consultation, and the recording:

i. does not contain any personal information relating to third parties (including a GP);
ii. is not disseminated or reproduced but kept personal to the patient;
iii. does not go beyond its purpose as an aide-memoire then the Data Protection Acts will not apply. This is known as an "S.4 exemption".

Where a recording is made for purposes other than for the management of his personal, family or household affairs, then it will fall under the Data Protection Acts.

This means that if a GP, during the course of his work, records a consultation, it falls under the Data Protection Acts. However, if a patient, a private individual, records that same consultation, then generally, the Data Protection Acts do not apply.

Where the Data Protection Acts do apply, the key issue is the giving of notice and obtaining consent in advance of the recording being taken. The recording of an individual GP or private person (where the recording is not for private use) is generally unlawful and should only take place to prevent or prosecute a crime or offence and should be of a focussed and short duration.

Although not yet specifically tested, the S.4 exception is unlikely to extend to circumstances where the patient discloses the recording to a third party without the prior consent of the other recorded parties in circumstances where personal data of the GP is recorded. Depending on the nature and the context of the disclosure, in these circumstances, a breach of the Data Protection Acts may occur.

The S.4 exception may not apply once a recording goes beyond its purpose as a record of the consultation, for example where the recording is disseminated or reproduced in a modified way.

This could relate to a situation where it is designed to cause detriment to another individual captured in the recording. Any such disclosure or publication, depending on the nature and context, may attract a civil action for damages and may also be a criminal offence.

PRIVACY LAW

There is a constitutional right to privacy under Article 40.3 of the Constitution.

However, it is not an absolute right and is balanced against a patient's right to freedom of expression conferred under the same Article. Again, the balance depends on the amount of personal information belonging to others contained within the recording.

Article 8 of the European Convention on Human Rights confers a right to respect for private and family life and states that "Everyone has the right to respect for his private and family life, his home and his correspondence." The extent to which this applies to a GP in his work life would also be balanced against a patient's right to freedom of expression.

CYBER HARASSMENT

There has been a growing awareness and concern in relation to issues such as cyber harassment and harmful Internet content in recent years. There is a gap in the law as it stands because Section 10 of the Non-Fatal Offences Against the Person Act 1997 states that while harassment can occur by any means, it must be persistent. Therefore a one off posting online of a recording would not constitute harassment under the Act.

This legislation was drafted in different times and was not intended to deal with Internet postings intended to damage a person's reputation. This problem was highlighted by the High Court in 2012 in a case of Tansey v Gill which related to content on the 'Rate Your Solicitor' website. In his Judgment, Mr Justice Michael Peart called on the Oireachtas to legislate for cyber crime as a matter of urgency. He said the Internet had given "ill-motivated" and "unscrupulous persons" an inexpensive way to vent their anger and their perceived grievances against any person. He stated "So serious is the mischief so easily achieved that in my view the Oireachtas should be asked to consider the creation of an inappropriate offence under criminal law, with a penalty upon conviction to act as a real deterrent to the perpetrator" and added that civil remedies provided an "inadequate means of prevention and redress".

In addition to the lack of penalties for offenders, it can be very difficult for a person affected by images or comments that are posted online trying to have the postings removed, and may involve expensive High Court Injunction proceedings.

On 27th September 2016, the Law Reform Commission (LRC) published its Report on Harmful Communications and Digital Safety. The Report contains 32 recommendations for reform and addresses the need for an overhaul of the legislation to promote digital safety, including an efficient take down procedure for harmful digital communications.

The Report acknowledges that the available processes and remedies may not be effective, and that the potential cost, complexity and length of civil proceedings may prevent victims of harmful digital communications from obtaining redress in court.

The proposed take down procedure would require a user to initially make his or her complaint directly to the relevant digital service undertaking, such as a social media site. If the content was not taken down in accordance with the time specified in the code of practice, the user could make a complaint to the proposed Digital Safety Commissioner who would then investigate the complaint. If the complaint were to be upheld, the Commissioner would direct the digital service undertaking to remove the specified communication and would revoke the certificate of compliance issued to the provider. If the digital service undertaking were to refuse to comply with the direction of the Commissioner to remove the communication, the Commissioner could apply to the Circuit Court for an order requiring compliance by the undertaking.

by Alison Kelleher,
Comyn Kelleher Tobin,
Medisec Panel Solicitors

Whilst welcomed universally, the LRC proposals remain a long way off becoming enacted legislation.

WHAT THIS MEANS FOR GPS

Unfortunately as the legislation stands, only in the most extreme of circumstances where reputation is damaged would a GP have a civil remedy against a patient for breach of data protection laws, defamation, financial loss or mental distress, arising from a recording of a medical consultation by a patient.

The maximum fine on conviction of an offence under the Non-Fatal Offences Against The Person Act 1997 is a fine of €100,000 or up to seven years imprisonment. Where a person suffers damage as a result of a breach of the Data Protection Acts, then the data controller or data processor may be subject to civil sanctions by the person affected. Ordinarily, the 'injury' suffered by a data subject will include damage to his or her reputation, possible financial loss and mental distress. Depending on the circumstances, the data subject concerned may also have a remedy by way of an action in defamation or breach of confidentiality. S31(2) of the Data Protection Act provides that the court has discretion to order any data material connected with the commission of the offence to be forfeited, destroyed or erased. A court can use this power to prevent any further damage being done by the use of the material or of the data.

PRACTICAL STEPS TO TAKE ONCE A RECORDING IS MADE

A. Where a request to record a consultation is made to a GP

A GP should always clarify what the purpose of the recording is. GPs may refuse to allow the patient to record the consultation and in those circumstances a GP should explain to the patient why they are not comfortable in allowing the recording, for example if it is felt that the recording of the consultation:

- may hinder the open sharing of information and views;
- cannot convey relevant non-verbal cues that affect an assessment;
- may be edited in ways that alter its significance;
- will be outside the GP's control and could be used to misrepresent the GP's actions or views.

If a patient refuses to stop recording or refuses to proceed with the consultation without the consultation being recorded, the GP should advise the patient that a recording of the consultation without the consent of others featured in it, depending on the nature and context of such disclosure, may lead to the commission of a criminal offence or result in civil proceedings.

B. Where a GP notices that a consultation is recorded covertly

In circumstances where a GP finds that a consultation is recorded covertly and against a GP's wishes, a GP should consider:

- halting the consultation;
- asking the patient to stop filming;
- asking the patient to delete the recording;
- advising the patient that disseminating a recording of the consultation without the consent of others featured in it, depending on the nature and context of such disclosure, may lead to the commission of a criminal offence or result in civil proceedings;
- reporting the incident to the Data Commissioner or the Gardaí, bearing in mind the overarching obligation to maintain patient confidentiality.

In circumstances where it is felt that the relationship between the GP and the patient has irreconcilably broken down, and it is felt by the GP that the only option is to remove the patient from the practice list then the GP may do so, following Medisec guidance on removing a patient from a practice list.

ADVICE ON MANAGING RECORDING IN YOUR PRACTICE

1. GPs should treat their interactions with patients on the basis that any or all consultations can and may be recorded by a patient.
2. If there is already a policy dealing with medical records in place within the practice, then including a suitable section to address the issue of patients recording staff may be helpful so that it can be referred to if this issue arises.
3. Where new or existing patients are asked to fill out a registration form including a consent under the Data Protection Acts, a suitable section could be included to confirm the practice's policy in relation to data collection and data processing. This form could include a warning to patients that the recording of consultations is not permitted.
4. It would be a matter for each individual GP to consider whether their practice would benefit from a sign or notice informing patients that disseminating a recording of the consultation without the consent of others featured in it, depending on the nature and context of such disclosure, may lead to the commission of a criminal offence or result in civil proceedings.
5. It is worth noting that the placing of notices prohibiting the recording of consultations is unlikely to deter a patient from recording a consultation, if they are so minded. It is also possible that the placing of such a notice may be counter-productive and could possibly alert a patient to the opportunity of recording a consultation if they were not already so minded.

If you have queries on this topic you can contact Medisec directly for advice.

HOME VISITS

While most patients are seen by GPs within their clinics, occasionally GPs will be asked to make a home visit. Citizensinformation.ie states that in the case of an emergency, a GP can be called and requested to make a house call during specific times. But should a GP be the first point of contact in the case of an emergency, as opposed to an ambulance? Or indeed what happens if the GP feels that a house call is unnecessary in the circumstances?

Although most GPs are happy to provide domiciliary care for the elderly, infirm and bedbound, due to ever increasing demands GPs cannot automatically visit any patient who requests a house call. GPs must however exercise caution when a request to make a house call is received and it is important that all surgeries have a policy in place setting out how a request for a house call is triaged.

As all incoming calls tend to be handled by non-medical personnel, it is crucial that the staff is properly trained in terms of trigger words to differentiate between routine and emergency. Creating a script with questions that the receptionist should ask could be helpful. If there is any doubt, the receptionist should err on the side of caution and contact the doctor immediately. Many practices now insist that all phone calls requesting house visits are put through to the GP and assessed with regard to necessity or urgency.

It is important that reception staff obtain as much information as possible on the phone and liaise with the Practice Nurse/GP, so the GP can ascertain whether the problem can be dealt with on the telephone, with a house call or if attendance to surgery or hospital might be more appropriate.

The Medical Council have liaised with the Preliminary Proceedings Committee on the issue of refusing to make a house call, and they have deemed that they are at the discretion of the doctor. The decision to make a house call should therefore be made by the GP on a case-by-case basis and if a decision not to make a house call is made, it is important that the GP is satisfied that the clinical symptoms complained of by a patient do not warrant a house call and that the patient is fit to attend the surgery.

Communication is critical when it comes to triaging the calls. An outright refusal to make a house call can become an issue, and the GP should ensure that the request and refusal is clearly documented, elaborating on the reason behind the refusal. Having a properly implemented triage policy in place could prevent a complaint to the Medical Council.

A CLINICAL APPROACH TO MEDICAL NOTES

HOW FAILURE TO KEEP ADEQUATE RECORDS CAN LEAVE AN OPEN GOAL FOR A PATIENT IN LITIGATION

By Kate McMahon, Kate McMahon & Associates, Medisec Panel Solicitors

"33.2 YOU MUST KEEP ACCURATE AND UP-TO-DATE PATIENT RECORDS EITHER ON PAPER OR IN AN ELECTRONIC FORM. RECORDS MUST BE LEGIBLE AND CLEAR AND INCLUDE THE AUTHOR, DATE AND, WHERE APPROPRIATE, THE TIME OF THE ENTRY, USING THE 24 HOUR CLOCK."

Medical Council Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 8th edition, 2016

The current edition of the Medical Council Guidelines makes it quite clear that there is an ethical responsibility for registered doctors to keep accurate medical records. It is also a condition of the Allianz professional indemnity policy with Medisec members that the insured "shall maintain full and accurate descriptive records of all medical advice and/or treatment".

What the Medical Council Guidelines do not specify is exactly what information those records should contain (other than the date, the author and the time of treatment).

It is established law that whilst failure to keep good quality notes might represent a breach of an ethical guideline, it does not automatically mean that the doctor in question has committed a negligent act. Medical negligence cases are based on expert evidence. The patient has a valid claim against a medical practitioner if he can establish by expert evidence that the standard of care afforded to the patient by the doctor fell below an acceptable standard.

In other words, the patient has to establish, on the balance of probabilities, that the treatment in question is substandard. The fact that the notes recording the treatment are themselves substandard is not a sufficient ground for a Plaintiff to succeed in their case.

Medical negligence claims are unique in the area of litigation in that they are, to a large extent, recognised as 'record cases' and expert evidence is based on the records maintained by the doctor, unlike other cases where expert evidence (such as engineering) can be based on the recollection of witnesses as to what occurred.

Equally, if a general practitioner faces a complaint to a regulatory body, much of the expert evidence called on both sides will be predicated on those records.

It therefore follows that whilst a failure to maintain good quality contemporaneous general practice notes will not necessarily lead to such a complaint being upheld or a finding of negligence against a hospital/practice, they do inevitably hamper a doctor's chances of having his or her professional reputation vindicated.

A failure to record vital information can allow a Plaintiff to effectively have a 'free run' as to the interaction between the patient and the doctor.

Here I will set out a number of instances in which a deficiency in record keeping has effectively forced a settlement of a case on the part of the GP.

Case A: A general practitioner carried out a routine neonatal examination of a baby at six weeks of age. Part of that examination ought to have included an examination of the baby's hips for detection of developmental dysplasia of the hip.

The handwritten note made by the doctor in relation to the six weeks check up simply said "6 week check – okay".

The explanation that the GP gave for this note is that it was his invariable practice to carry out a number of examinations as part of the developmental check and that in conducting such an examination, he always checked the infant's hips. If he had detected any abnormality in any specific element of the check-up (including the hips) he would most certainly not have written "6 weeks – okay". The fact that he made that note relayed to him the information that all elements of the examination were normal.

It is accepted by all medical experts that some hip dysplasia cannot be detected at the six-week check-up, even where the GP is acting with reasonable care.

However, the fact that there was no specific information whatsoever recorded in this chart confirming examination of the hips allowed some credibility to attach to the mother's evidence that the doctor did not check her baby's hips at all on the occasion in question, which would of course be a negligent act on the part of the doctor.

This case is a classic example of where an absence of an important piece of information being recorded in the patient's notes will allow the Court to come to a conclusion that the patient's version of what happened on the day in question is more likely to be preferred than the doctor's evidence as to what he routinely does.

It is very difficult for a doctor, perhaps years after a visit by a patient, to have a clear recollection as to the exact interaction with the patient.

By contrast, the patient, who was probably only attending the doctor on a couple of occasions per year, will say that they can vividly remember what was said to them and by them and what examinations took place.

Case B: A young female patient presented to her GP with vague complaints of chest pain.

A chest infection was diagnosed (the doctor being reassured that she had undergone a normal CT scan of her chest some five months previously). Over the next eight-month period she re-attended on a total of nine occasions.

The standard of note-keeping by the doctor was not of his usual standard, and with the exception of visits for Depo-Provera injections, it was not clear at all what symptoms were reported to the doctor, what examinations were carried out (none were documented) and yet antibiotics and analgesics were given regularly to the patient over this period.

After an eight-month period, and following consultation with another general practitioner, the patient was referred to secondary care, where she was diagnosed with Hodgkin's disease.

When the High Court claim was launched, the patient was now claiming that throughout those visits she made multiple complaints to the doctor of chest pain, pins and needles, decreased appetite and night sweats.

The expert's view, formed after reviewing all of the records, is that almost certainly this was a very atypical presentation of the disease over a relatively short period of time, and for which the GP could be excused for either not making the diagnosis or failing to refer on for a consultant opinion.

It appears in this patient's case that the disease was advanced within the chest before any neck lymph nodes arose. The difficulty from Medisec's perspective is that all of the supportive reports, which effectively exonerated the doctor of the allegations made by the Plaintiff's lawyers, were qualified by their comments on the lack of documentation.

Ultimately, the case was compromised and dealt with well before it came before the Courts.

Other than the basic information contained in paragraph 33.2 of the Medical Council Guidelines, there is no exhaustive list of what information should be contained in a general practitioner's clinical notes.

Given that patients will be presenting with widely different symptoms and conditions, it is quite simply not possible to provide such an exhaustive list.

However, at a minimum, we would expect to see the following information recorded:

- Date and, where appropriate, time (using the 24-hour clock)
- Author
- Presenting symptoms
- Examinations carried out
- Impression/diagnosis
- Prescription (if appropriate)
- Referrals (if appropriate)
- If the patient is advised to return for further treatment

We would stress that this is the minimum information required, and in other cases it may be that the notes will have to be much more comprehensive.

Particular care should be taken when filling out insurance claim forms on behalf of patients. We are aware of at least three cases where the information furnished in claims forms was at variance with what was contained in the records and ultimately such incompatibility may hamper the doctor's prospects of a successful defence.

The fact that information is being input by the doctor into a form created for the purpose of an insurance claim does not in any way reduce the importance of this information, and it will form part of the patient's medical record.

In conclusion

The primary purpose of maintaining high quality medical records is to enhance the patient's care.

In the context of litigation, however, the same notes will be relied upon by the general practitioner in seeking to rebut any allegations of professional negligence or to deny any wrongdoing in respect of a Medical Council complaint made against them.

Such a claim or complaint will be made, at best, weeks (and in reality, years) after the event.

With the benefit of hindsight, and even being as honest and objective as possible, patients will have a different recollection of their interaction with a general practitioner when there has been an adverse outcome.

The general practitioner, for their part, is highly unlikely to have a distinct recollection of a perfectly normal routine interaction with a patient, years after the event.

Where high quality medical records are maintained over a prolonged period of care, those records will usually carry considerably more weight with a Trial Judge than either party's (the patient or the doctor) recollection of events years after those events.

Private Medical Attendance (PMA) Reports

DOES THE PATIENT UNDERSTAND WHAT THE GP WILL BE DISCLOSING?

PMA reports may cause difficulties in General Practice for a variety of reasons, and we often deal with queries about them here in Medisec.

It's important to remember that if the GP omits medical information when completing a PMA report, which could subsequently be judged 'relevant' to a patient's clinical status, then a claim could subsequently be rejected years later.

Paragraph 40.5 of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners says:

"If you are asked to conduct an examination and give the results to a third party such as an insurance company, employer or legal representative, you should explain to the patient that you have a duty to the third party as well as the patient, and that you cannot keep relevant information out of the report. You should be satisfied that the patient understands the scope and purpose of the report…"

The medico-legal risks surrounding PMAs and medical assessments for insurance companies are often in the context of consent and extent of disclosure, but other aspects can also cause difficulties for the GP. Some common issues are highlighted below:

1. DELAY IN COMPLETING REPORTS

This can cause significant difficulty to a patient keen to have insurance in place for example for a mortgage approval. The Irish Medical Council Guide to Professional Conduct and Ethics 2016 says: "40.3 You should provide reports promptly so that the patient does not suffer any disadvantage."

2. NO CONSENT

It is not unknown for an insurance company to request a PMA report and omit any signature of consent to release medical information from the patient. It is important to ensure full, valid and informed consent. See further details below.

3. ADEQUATE CONSENT

A faded photocopy of a patient's signature is often the only indication that the patient has consented to disclosure of all his medical details. How can the GP know whether this patient understood the relevance of this permission? Did the patient realise that they were giving permission for disclosure of all their medical history, including long forgotten illnesses and ailments, etc.? Was the consent truly 'informed', and did the patient understand the extent of the disclosure? We recommend that the GP offers to go through the completed PMA report with the patient to ensure the patient understands the information that is being disclosed and the scope and purpose of the report.

CAN THE GP DISCLOSE INFORMATION ABOUT GENETIC CONDITIONS AND INHERITABLE ILLNESSES?

The Disability Act 2005 and the Code of Practice on Data Protection for the Insurance Sector directs that an insurance company cannot take the results of an applicant's genetic screening into account whatsoever when considering an application for an insurance policy. A GP is not obliged to reveal the results of any genetic screening to the insurance company, and if they do so, the insurance company cannot take these into account. However, where a patient is the sufferer of a genetic illness, then his clinical condition and diagnosis can be disclosed. A common condition would be where a patient has been identified as a carrier of the gene for haemochromatosis. If clinically well, and suffering no sequelae the result need not be disclosed. If the patient is suffering any consequences of haemochromatosis, say, cirrhosis and diabetes, or is going for regular venesection, then this may be revealed.

IS THE GP OBLIGED TO ENTER DETAILS OF THE PATIENT'S FAMILY HISTORY?

If a GP has information about a member of the patient's family, and that person is identifiable, then the GP should have the consent of that person in order to reveal their medical past. It is recommended therefore to leave it to the patient themselves to offer their family history to the insurance company if requested. The GP should inform the patient of the need to disclose all relevant information and to act in utmost good faith.

The issue of confidentiality and extent of disclosure raises its head so often here in Medisec, that in order to comply with the Medical Council Guidelines and ensure the patient consents to release of the report and "understands the scope and purpose of the report", we recommend that the GP offers sight of the report to the patient and at an absolute minimum informs the patient what will be in the report before it is submitted to the insurance company. If a patient unreasonably objects to any findings in the report, the patient is effectively not consenting to disclosure of the report. The GP should not compromise their position by omitting any relevant details from the report and should simply write on the relevant section of the form "no consent from the patient to disclose" or decline to submit the form in such circumstances. The GP should document his or her discussions with the patient carefully in the medical records.

If you have any queries about preparing PMA reports, contact us for further advice.

Doctors' HEALTH

and the 2016 Guide to Professional Conducts and Ethics for Registered Medical Practitioners

By Dr. Rita Doyle M.B. BCh. BAO DCH M.I.C.G.P, Chair of Health Committee, Irish Medical Council and Medical Member of Irish Medical Council

As doctors, our own health has never been a priority, despite the old adage that if we don't look after ourselves, how can we look after others? This is changing and many of the colleges now have Doctors Health Programmes, or at least resources that doctors can refer to if they have personal health issues.

The Medical Council's new Ethical Guide addresses the responsibility we, as doctors, have to look after our own health:

- 58.1. You have an ethical responsibility to look after your own health and well-being. You should not treat or prescribe for yourself. You should have your own general practitioner, who is not a member of your family, and you should be vaccinated against common communicable diseases.

- 58.2. If you have an illness which could be a risk to patients or which could seriously impair your judgement, you must consult an appropriately-qualified professional and follow their advice. This professional will have a dual role: to help and counsel you and to make sure you do not pose a risk to patients and others. If such a risk exists, you must inform the Medical Council as soon as possible.

Paragraph 5.1 spells out very clearly that we must look after our own health and well–being. That means not only reacting to illness and health issues as they arise, but also being proactive in staying well. The maintenance of both physical and mental health requires effort and focus. The balance between work and pleasure needs to be attained.

Prioritising exercise in our daily life when we spend a lot of time driving around attending to patients requires motivation and effort on our part. It is my experience that the young doctors are better at this than those of my generation but they may not be as good at other things. Keeping up with our friends and having 'fun' are all part of a healthy lifestyle.

"You should not treat or prescribe for yourself"
Self-prescribing is never a good idea. You cannot be unbiased in your decisions and the idea that it is only something simple is erroneous. If you need a prescription then you need to see a doctor. The idea that you should have your own General Practitioner is anathema to many doctors and the rider that they should not be a member of your own family is an important one. All GPs should register with a GP and go as and when it is necessary, in the same way you would hope that your patients would avail of you. While for some this is difficult, the treating GP should treat the doctor as a patient and not as a colleague. The relationship on both sides can be fraught with difficulty with the doctor patient often presenting with their interpretation of the symptoms and the treating doctor possibly presuming that the doctor patient understands more than they actually do. Presumptions abound, and care with this relationship is important and a learning trajectory.

"You should be vaccinated against common communicable diseases"
This was originally meant to mean Hepatitis B, however since all doctors have been vaccinated against Hep.B as a matter of course, it now refers to Influenza and other common communicable diseases such as Pertussis, Measles, Mumps, Chicken Pox, etc. It's not just a good idea to get appropriately vaccinated. You have an ethical responsibility to do it.

Section 58.2 tells us what we should do if we have an illness that could be a risk to patients. We must consult an appropriately qualified professional and follow their advice. If you have an illness that could impair your judgment, then you must inform the Medical Council. Illnesses that might impair your judgment include an addiction to alcohol or drugs. If you have been prescribed opiates or strong tranquillisers, then you should always ask your prescribing doctor whether it is safe for you to work.

If you are being treated for depression or anxiety, then you should ask your treating professional whether you should be working, with a regard to patient safety and your own health and well-being, both of which are equally as important. The Medical Council's Health Committee is there to help doctors who are suffering from ill health and their role, which of course includes protecting the public, is primarily to help doctors to stay on the Register or return to the Register after or during a period of ill health.

While the Committee was originally set up by the Medical Council in response to the need for such a committee under the Medical Practitioners Act 2007, the Council now has a statutory obligation (Section 20.4) to have such a committee, as even the legislators now seem to acknowledge that doctors are not immune to ill health.

There are several paths of referral to the Health Committee. The doctor can be referred by the Fitness to Practice Committee but may also self-refer or be referred by a third party. If you have concerns about a colleague's abuse of alcohol or drugs or other health problems, paragraph 59.1 quite clearly states that you have an obligation to report it, if there is a risk to patients:

> "If you are concerned about a colleague's health or professional competence due to the misuse of alcohol or drugs, a physical or psychological disorder or other factors, your primary duty is to protect patients. If there is a risk to patient safety, you must inform the relevant authority of your concerns without delay. If there is no current risk, you should support your colleague by advising them to seek expert professional help or to consider referral to the Medical Council's Health Committee."

When a referral is received by the Health Committee, support is offered. The Health Committee membership is made up of:

- Minimum of two General Practitioners - currently five and myself as Chair
- Two Psychiatrists – including one with a special interest in addiction
- One Occupational Health Physician
- Two Psychotherapists – including one with a special interest in addiction
- Two lay members

A doctor offered the support of the Health Committee will be monitored by the Committee as to their compliance with treatment provided in an appropriate healthcare setting, i.e. via reports from the doctor's own treating practitioners. The Committee does not provide treatment or take on the responsibility of a patient/doctor role.

The referred doctor is reviewed by two members of the Committee, with such reviews taking place after hours with confidentiality guaranteed. During the review session, the Committee members will discuss received medical reports with the doctor and any issues relevant to the doctor's health that the members consider appropriate at that time. The doctor may choose the specialist but the Committee must be satisfied that the specialist is relevant to the doctor's health problem.

The Committee may advise the doctor on return to work and will support them generally in their recovery, with ongoing review sessions taking place. A doctor under the care of the Committee will continue to be supported until such a time that the Committee feels it is appropriate to discharge them.

If you, or a colleague, has a health issue that might fall under the remit of the Health Committee, an informal approach to the Chair for advice would be facilitated.

In summary:

1. Be proactive about your own health.
2. Register yourself and your own family with a GP of your choosing.
3. Consult your GP about your health.
4. Never self-prescribe.
5. If you have concerns about yourself or a colleague, consider referral to the Health Committee for support, or contact your indemnifier who can give you advice about your available options.

DOCTORS

AND THE ASSISTED DECISION-MAKING (CAPACITY) ACT 2015

BY EAMON HARRINGTON,
COMYN KELLEHER TOBIN,
MEDISEC PANEL SOLICITORS

The Assisted Decision-Making (Capacity) Act 2015 updates the law on decision-making by people with limited mental capacity, now or in the future. Although the Act has not yet been brought into force, so its provisions do not yet apply, it will have particular relevance to issues concerning all patients, not just those patients suffering from intellectual disabilities, head injuries and elderly people with diminishing cognitive reasoning.

THE ACT IS RELEVANT TO:

- patients who require assistance in exercising their decision-making capacity, whether immediately or in the future;
- the appointment of decision-making representatives for such patients to assist them in decision-making or to make decisions jointly with such persons;
- the making of advance healthcare directives by patients of their will and preferences concerning medical treatment decisions, should such a patient subsequently lack capacity;
- enduring powers of attorney.

KEY POINTS FOR DOCTORS TO NOTE

1. CHANGE IN DEFINITION OF CAPACITY

Whereas previously it was assessed on a 'status' basis – you either had it or you didn't – now it can be assessed on a 'functional' basis. This is a major change.

Rather than a fixed idea that a person can or cannot make any decisions, capacity is therefore to be understood as a fluid, changeable concept, depending on the circumstances of the person at the time and the nature of the decision to be made.

The new test is a 'functional' one:

"A person's capacity shall be assessed on the basis of his/her ability to understand the nature and consequences of a decision to be made by him or her in the context of the available choices at the time the decision is made."

The Act recognises capacity as a changeable concept, that must be understood in the context of the specific decision that the patient must make at that specific time. The legislation provides that there is a presumption that the patient has capacity unless the contrary is proven, and that the "will and preferences" of the patient should be central to the decision-making process. For instance, a patient cannot be considered incapable of making a decision merely because it would be deemed 'unwise'.

Under the Act a patient is deemed to lack capacity where they are unable to:

(a) understand the information relevant to the decision;

(b) retain that information long enough to make a voluntary choice;

(c) use or weigh that information as part of the process of making the decision;

(d) communicate his or her decision.

This test does not encompass patients who are capable of understanding matters presented to them in a way appropriate to their circumstances (e.g. through pictures or plain language), or patients who can only retain information for a short period.

There is a three-tiered approach for determining what degree of assistance may be required by a 'relevant person' (i.e. a patient whose capacity is called into question or may shortly be in question) in making decisions regarding their personal welfare (including 'healthcare') or property/affairs:

(i) decision-making assistant;

(ii) co-decision-maker;

(iii decision-making representative.

2. ADVANCE HEALTHCARE DIRECTIVES

Anyone aged over 18, and who has capacity, may make an advance healthcare directive (AHD).

This will enable the directive-maker to be treated, if they lack capacity in the future, according to their will and preferences. AHDs are not applicable to general and mental health, and are not applicable where a person is suffering from a mental disorder and involuntarily detained under part 4 of the Mental Health Act 2005.

While a refusal of treatment must be complied with (if the treatment and circumstances are clearly identified in the AHD), a request for a specific treatment is not legally binding. A Relevant Person, if he or she has capacity and is over 18 when making the AHD, is entitled to refuse treatment for any reason, including a reason based on religious beliefs.

An AHD is not applicable to life-sustaining treatment, unless this is substantiated by a statement by the directive-maker to the effect that the AHD is to apply, even if his or her life is at risk.

A directive-maker may designate a named individual to exercise relevant powers, that is, to be their healthcare representative (HR). The HR has the power to ensure that the terms of the AHD are complied with, and the directive maker may confer powers that allow the HR to advise and interpret the directive-maker's will and preferences, and to consent or refuse treatment, up to and including life-sustaining treatment, based on the known will and preferences of the directive-maker by reference to the AHD.

Where there is an ambiguity in how the AHD is to apply, the healthcare professional must consult with the HR or friends and family. Where it is not resolved, it must be resolved in favour of the preservation of the directive-maker's life.

Medisec will inform members when the provisions of the new Act become operative. In the meantime if you have any queries relating to assessing capacity or this article, please consult Medisec for further advice.

TAIL COVER *explained*

Tail cover is probably the number one fear that GPs have when changing indemnity provider from a claims-occurred provider to a claims-made one. However, when it is explained, it is not as daunting or as expensive as you might think.

Let us examine the types of Professional Indemnity Cover currently available for GPs in Ireland.

CLAIMS-MADE

A claims-made insurance policy, which is the type we offer, provides cover for those events and claims that occur and are reported while the policy is in effect. All coverage ceases on the date the policy is terminated and hence you must ensure you have tail or run off cover to deal with claims that may arise once you retire or leave practice.

CLAIMS-OCCURRED

Occurrence-based cover indemnifies events that happen during the period the claims-occurred policy is in effect, regardless of when a claim is filed, even if you are no longer covered by that claims-occurred indeminifier.

THE COST OF PROFESSIONAL INDEMNITY COVER

Research indicates that claims-made policies are substantially cheaper than occurrence policies. For instance, the Medisec Master Policy, underwritten by Allianz plc, offers full cover including unlimited out of hours sessions at €5,207.94* per year. We understand that the claims-occurred cover options available in Ireland are substantially more expensive.

However, when comparing both options you must factor in the tail or run off costs of a claims-made policy. At Medisec, we reward loyalty and for members who are 10 years with us prior to their 65th birthday, there is no tail cover cost at retirement as it is paid by Medisec.

For those who have not been with us for 10 years prior to their 65th birthday, or decide to retire early, tail cover currently stands at circa €13,000*. It is paid in instalments over an 8 year period and covers any claim or event at any time after their retirement.

New members inform us that these figures give peace of mind and a realisation that paying for tail cover may not be as painful as they initially think, as within two or three years they can recover such cost on the savings they make on their annual subscription if they move from a claims-occurred policy to Medisec.

We've talked about the cost and the myths surrounding tail cover. But if you talk to any of your colleagues who are Medisec members and who have used our services, they will say that the most important aspect of our offerings has not been the cost factor but the support they receive at a very stressful time, which comes from an experienced team based in Ireland and therefore understands the challenges faced by GPs working in Ireland today.

*Current quoted rates as at July 2016 which are subject to annual change.

YOUR CHAPERONE POLICY

The Medical Council has introduced new guidance with regards to the provision of a chaperone during patient examinations.

To help make patients aware of your chaperone policy in a simple and easy way, we have designed two posters for your waiting room.

HOW TO ORDER YOUR FREE POSTER

Simply call or send us an email, stating which poster you would like along with your name and practice address.

Email:
info@medisec.ie

Phone:
01 661 0504

WORKSHOP FOR YOUR PRACTICE STAFF

As part of our commitment to helping GPs and their practice staff provide the highest standards of patient care, we are running a series of workshops in our offices for practice managers, practice nurses and administration staff.

The workshops will address many of the medico-legal challenges that routinely arise in general practice, and by tackling these issues with practical guidance, the hope is that attendees will be more risk-aware and in turn, promote a safety culture within their teams.

As the five initial workshops were oversubscribed, we will run further practice staff workshops in the New Year and workshops for GPs on a range of topics including clinical risk self-assessments, requests for records and communication. If your or your staff members wish to attend future workshops, please register your interest by emailing **aoifeohiggins@medisec.com** or calling **01 661 0504**.

SUPPLEMENTAL MEMBERSHIP FOR GP TRAINEES

BECAUSE SOMETIMES THE CLINICAL INDEMNITY SCHEME COVER ISN'T ENOUGH

If you're a GP Trainee on an ICGP approved training scheme, then the Clinical Indemnity Scheme covers you in relation to the provision of professional medical services in the course of your training. However it doesn't cover you for Good Samaritan work, medico-legal advisory queries you may have, or for legal advice in the event you are complained to the HSE or Medical Council. And that's why we've decided to help.

For just €150 per annum, you get unrivalled complaints and disciplinary assistance, 24/7 advice and cover for Good Samaritan Acts, so that while you're training, you'll have the peace of mind to give the best patient care possible, even during stressful times in your career.

And when you join Medisec, you're joining a not-for-profit company, founded and owned by over 1,650 GPs in Ireland, for GPs in Ireland. An Irish company that really will be with you, at every step of your career.

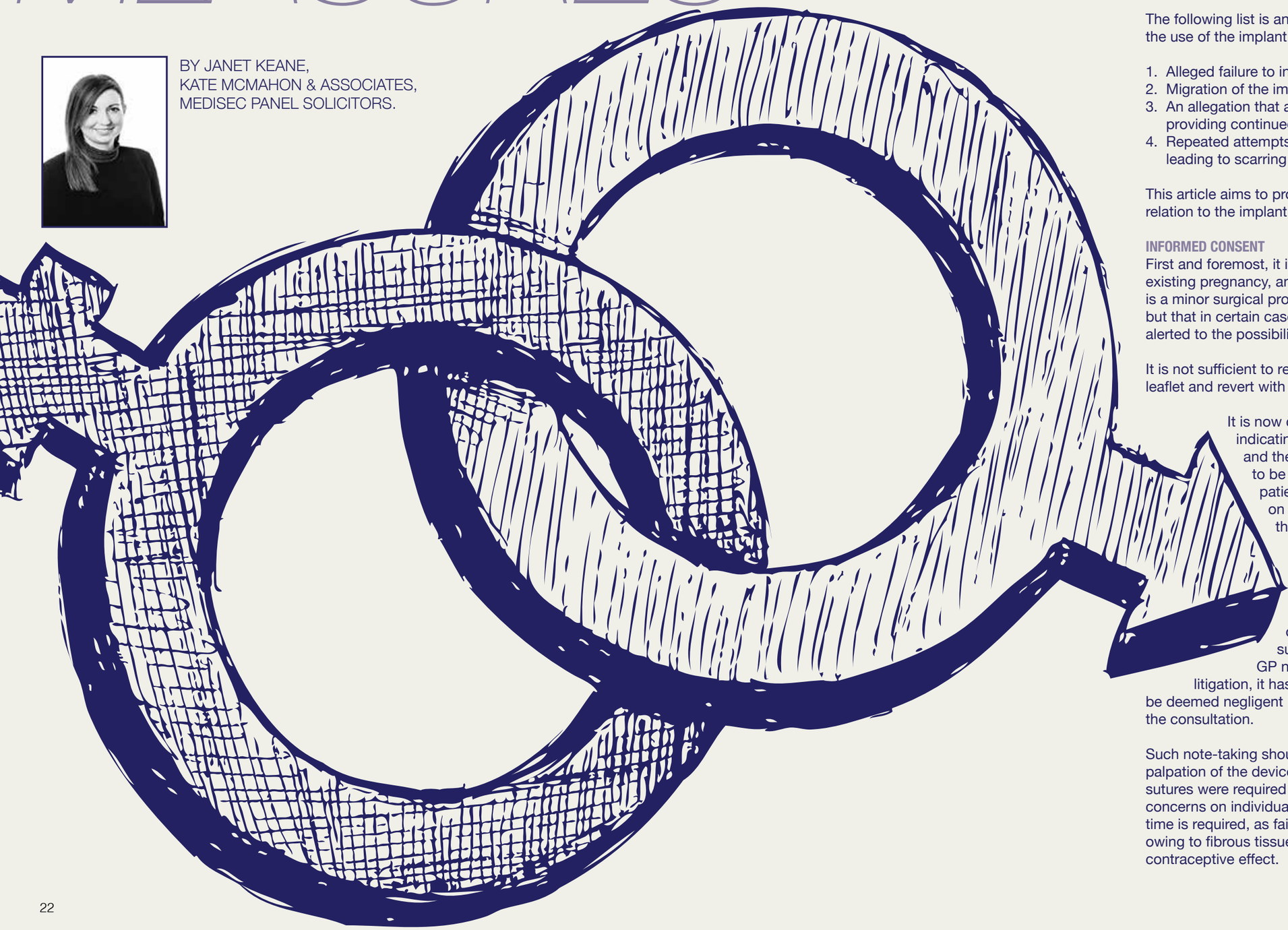
Please note: this doesn't cover you for locum work as a GP, or for the provision of medical services in the course of training in your GP practice or scheme hospital as this is covered by the CIS.

Interested? Either fill out the form which you can download from our website **medisec.ie** or call us on **1800 460 400**.

PROTECTIVE MEASURES

The emergence of the etonogestrel contraceptive implant, or subdermal contraceptive implant ('implant') has seen its prevalence amongst patients rise and rise. It is the fastest growing contraceptive device on the market. From a medico-legal perspective however, we have encountered numerous and varied cases brought in relation to its insertion and removal.

BY JANET KEANE,
KATE MCMAHON & ASSOCIATES,
MEDISEC PANEL SOLICITORS.



The following list is an illustration of the diversity of cases instituted arising from the use of the implant:

1. Alleged failure to insert correctly or at all, leading to an 'unwanted pregnancy'.
2. Migration of the implant.
3. An allegation that a portion of the implant was left in situ on removal, providing continued contraceptive cover.
4. Repeated attempts to remove despite the device not being palpable and leading to scarring because of the attempts made.

This article aims to provide the GP with an awareness of how potential litigation in relation to the implant can be avoided.

INFORMED CONSENT

First and foremost, it is of the utmost importance to exclude the possibility of an existing pregnancy, and that the patient is advised that the insertion of the implant is a minor surgical procedure with the potential for not just a small discrete scar, but that in certain cases scarring can be significant, and the patient should be alerted to the possibility of keloid formation.

It is not sufficient to request that the patient simply reads the patient information leaflet and revert with any questions they may have.

It is now considered normal practice to have a written consent form indicating the details of the procedure, including adverse effects and the fact that no method of contraception can be considered to be 100% effective. The GP should go through this with the patient and ensure the patient signs and dates the consent form on the day of the procedure. This provides great protection for the GP, should things subsequently go wrong.

RECORD KEEPING

Linked heavily to the issue of informed consent is the particular standard of record keeping which should prevail, specifically with regard to insertion and removal of the implant. Normally in medical negligence litigation, substandard record keeping would not by itself render a GP negligent. However, during the course of specific implant litigation, it has been suggested to us by a body of experts that a GP could be deemed negligent if there is an absence of adequate documentary evidence of the consultation.

Such note-taking should make reference to a record of exclusion of pregnancy, palpation of the device, potential side-effects and warnings given, whether sutures were required and why, the location of the insertion and any other specific concerns on individual presentations. The notification to return in three years time is required, as failure to do so can exacerbate any difficulties in removal owing to fibrous tissue formation around the implant, in addition to the loss of the contraceptive effect.

REMOVAL OF THE IMPLANT

We are repeatedly faced with the scenario of a GP making attempts to remove the implant at the patient's insistence, despite having reservations in relation to palpation and location of the device. This can create potential for a 'scar case' but, moreover, it raises the question when is it appropriate to abandon the removal attempt and refer for ultrasound guidance?

The cardinal rule in this instance is, if you cannot palpate the implant, you must refer for radiological and/or surgical assessment.

Only one attempt at removal should be made, and if this fails then the patient should be referred to a surgical colleague, rather than having the patient return on another occasion for 'another go', resulting in further scarring and potentially the need to still refer the patient for surgical exploration.

There is a heightened duty for informed consent in this regard and needless to say, if you were not the GP who originally inserted the device. The potential adverse effects on removal are:

- Bruising
- Tenderness
- Irritation and itching
- Pain
- Paraesthesia
- Wound infection
- Scarring
- Failure of removal attempt
- Incomplete removal

TRAINING

Over and above the guidance provided by the implant manufacturers, a number of training courses and qualifications are now run in relation to the provision of such contraceptive implant services. In recognition of the rate of usage of the implant, the ICGP runs workshops, masterclasses and advanced certification in long-acting reversible contraceptives (LARC). If the GP has any queries, then there are ICGP-appointed LARC tutors who you can consult.

MIGRATION

As already mentioned, there are well-recognised complications with regard to the implant.

One rare complication is the potential migration of the implant. In some cases it may just be a few inches, but can make removal difficult. There are reported cases of the devices migrating to the thorax, presumably where they had been inadvertently inserted intravascularly. While it can be argued that the patient is asked to take away the patient information leaflet, study it and revert with any questions, the lack of parity between GP and patients in relation to knowledge as to this warning should be addressed by the GP. If there is any abnormal or prolonged bleeding on insertion and if the GP is unable to achieve haemostasis with the use of a single suture and pressure at the excision site, we have been advised by expert GPs that this should be documented and the potential for migration considered. The suspicion being that the implant may have been inserted into a vein in the subdermal tissues.

A record of palpation post insertion is always necessary, and it is recommended that the patient also palpates the device and that this is recorded.

It is recommended that the device is measured on removal in order to eliminate the possibility of a broken piece of the device being left behind.

THE LEGAL TESTS

A frequent question we encounter from general practitioners is what is actually legally recoverable by a patient? This is, needless to say, separate to any issues with regard to obvious scarring or demonstrable physical injuries.

In wrongful birth claims, the courts have been divided across the common and civil law jurisdictions around the world as to whether certain types of damages may be recoverable.

There are two written High Court decisions in this jurisdiction: Byrne v Ryan (2007) IEHC 207 and Hurley Ahern and Ahern v Moore (2013) IEHC 72 (Hurley Ahern v Moore). As it is still relatively unchartered and novel territory, these fall to be considered separately.

With regard to the recoverability of damages for the costs of bringing up an unplanned child, in Byrne v Ryan the Plaintiff had undergone a tubal ligation operation that had failed. When she discovered she was pregnant for the first time after the operation, she believed she had already conceived before the tubal ligation and therefore did not question the success of the operation. However, she subsequently became pregnant again. Both pregnancies were carried to full term and healthy children borne of them. The Plaintiff sought:

a) Damages for the costs of rearing the two healthy children;
b) Damages for the pain, suffering and inconvenience of pregnancy;
c) Damages for having to undergo a second sterilisation.

Kelly J rejected the claim at a), and allowed the Plaintiff to recover for b) and c). Kelly J's decision and reasoning on this issue was cited with approval by Ryan J in Hurley Ahern v Moore. The conclusions of those courts were that in essence it would not be fair or reasonable to visit a doctor responsible for a negligent sterilisation procedure with the costs of bringing up a healthy child, that the birth of such child, even if unplanned, is an unquantifiable benefit which far outweighs the costs incurred in raising him or her.

Turning another strand of recoverability, that being pain, suffering and inconvenience of an unplanned pregnancy in Hurley Ahern v Moore, Ryan J decided the issue in favour of allowing recovery to the Plaintiff. The rationale for allowing recovery was that it was foreseeable if a sterilisation operation failed that pregnancy may occur and that the pain, discomfort and inconvenience of pregnancy, along with associated extra medical expenses, was a consequence which was not too remote to be recoverable and did not need to be excluded on the grounds of principle or public policy. Ryan J awarded the Plaintiff the sum of €100,000 in respect of the injuries occasioned by the wrongful birth. The award may seem very high; however, the factual circumstances in Hurley Ahern v Moore may be seen to justify it and also serve to distinguish it from other cases.

Mrs Hurley Ahern suffered from a genetic blood clotting condition which made pregnancy particularly risky for her and was the reason she had undergone sterilisation. The child of the pregnancy was born by emergency caesarean section at 34 weeks and suffered severe disability that caused him to spend the six months of his short life in hospital before he died. Ryan J held that as his existence resulted from the Defendant's negligence with regard to the failed sterilisation, "the experiences that followed and resulted from the negligence in this case were a continuum".

Lastly, in relation to the third strand of recoverability, being loss of autonomy in deciding whether to have more children, it was accepted that only nominal damages should be awarded in this respect as the conventional award would not be intended to be compensatory. It would afford some measure of recognition of the wrong done.

IN CONCLUSION

The popularity of subdermal implants continues to grow. Therefore, in recognition of the frequency with which a GP will have to perform this minor surgical procedure, investment in specific training, accreditation and an increased awareness as to the informed consent requirements should be highlighted to all.

COMPLAINTS POLICY IN GENERAL PRACTICE

"Why would you have a complaints policy? It will only encourage patients to complain!"

Wrong! A good complaints policy in the practice with clear notices in the waiting room or in the practice leaflet will provide an outlet for a disaffected patient to air their dissatisfaction about an event which may have upset them. It will help on so many counts:

- A complaints policy with a designated, named complaints manager can alert the practice to events and situations they may have been unaware of, e.g. the behaviour or habits of a staff member, the attitudes of a receptionist or GP.
- It gives the GP an opportunity to engage with the patient before the situation escalates.
- Having a complaints policy may divert a complaint from going directly to the Medical Council.
- Where an event or situation upsets a patient, if they see their complaint is acknowledged and taken seriously and steps are taken to prevent continuation or repeat of the incident, it can cement a positive relationship with the patient and perhaps deter the patient from taking a more legal route and making a claim against the doctor.

In Medisec we frequently see how a well-managed complaint, with good communication and timely engagement with the patient, can end harmoniously. Conversely we see where complaints which are not acknowledged or dealt with in a timely manner can provoke the patient into making a Medical Council complaint or issuing a medico-legal claim.

We can provide you with a proforma Complaints Policy which you can adapt for your practice. If you would like to request one, please email info@medisec.ie

ORDER A WAITING ROOM POSTER

Having an open complaints policy could save you time and trouble down the line - by dealing with complaints in-house, you could avoid a negligence claim or a Medical Council complaint. This is why we've made a waiting room poster encouraging patients to get in touch with you if they are unhappy with any aspects of the service they have received.

TO ORDER A FREE POSTER FOR YOUR SURGERY, PLEASE CALL US AT 01 661 0504 OR EMAIL INFO@MEDISEC.IE

Insurance cover for your practice staff

Have you got adequate cover in place?

As you will be aware, in March 2014 the Irish Nurses and Midwives Organisation (INMO) took the decision to remove practice nurses from the INMO Medical Malpractice Programme, and as a result the demand for practice nurse and staff cover has become more prevalent. Medisec (underwritten by Allianz Plc) facilitated an insurance solution for GP Practices in the form of a GP Practice Policy.

It is important to distinguish this from cover we currently extend to practice nurses, whereby if your nurse is employed directly by you (as a sole trader so to speak) and not by a practice, partnership, clinic or other legal entity, then they are covered under your policy. Put simply, if the practice nurse is employed by you directly and paid by you as a sole practitioner GP, then he or she is covered under your policy. If, on the other hand, the practice nurse is employed and paid by a partnership clinic, company or other corporate entity which you may have set up with other GPs or otherwise, then the practice nurse is not covered under your Medisec policy.

If you are not the direct employer of practice staff, you should consider purchasing a Practice Malpractice Insurance policy. If a practice nurse is involved in an incident while working for a GP in your surgery that results in injury to a third party, that third party may decide to sue. If they decide to make a claim, the third party will sue the "employer" of the practice nurse as the employer may be vicariously held liable for the actions of his or her employee.

A Malpractice Policy will cover legal liabilities arising from the employment of all staff, not just practice nurses, and will extend to practice nurse midwives, phlebotomists, dieticians, administration and clerical staff.

If you would like to find out more, please get in touch with us.

QUICK TIPS

OUT OF HOURS LAB RESULTS

In order to avoid a crisis, usually on the Friday of a Bank Holiday weekend, please ensure that your local lab has your contact details for any critical lab reports which may come in after hours.

In many cases, if the GP is not available, these results are communicated to the local Out of Hours service. The unfortunate GP on duty has no context for the abnormal result, no access to the patient records, and probably no phone contact details for the patient. The Out of Hours GP must then make a judgement call regarding whether the result needs immediate action, or whether it can wait until the next working day. Once the Out of Hours service is in receipt of the information, there is an onus on them to make that judgement call, impossibly difficult in some cases. Remember: if you ordered the investigation, you are responsible for the result!

BUDDY SYSTEM

If you are on leave, whether for a few days or a number of weeks, you should have a formal 'Buddy System' in place. This is where you designate a colleague to take charge of your post and your lab results in your absence, in order to take any critical action that may be needed. Consider a significantly elevated potassium result sitting in your inbox for three weeks, or haemoglobin of five where the patient needs urgent transfusion awaiting your return from walking the Camino.

BEWARE OF ASSUMING LIABILITY FOR OTHERS

GPs are reminded not to sign agreements whereby they assume responsibility and/or liability for the actions of others, who are neither employed directly by a GP nor a GP practice, without first carefully considering the resulting legal and supervisory obligations for the GP and practice.

RISK REDUCTION BY AUDIT

Stuck for an idea for your annual audit? Consider these risk reduction exercises that would also comply with your Medical Council CPD audit obligations.

- Critical Medications: consider performing an audit of all your patients on repeat prescriptions of certain critical medications, e.g. Methotrexate, Lithium, Digoxin or NOACs, amongst others. Using your software, pull up details of all patients who are maintained on one of these medications, and look at whether they are up to date with their blood tests.

- PSA: missed follow up of raised PSA is one of the more frequent causes of claim or complaint in Medisec. An easy audit would be to audit all your PSAs performed in the past two years and identify whether all the elevated PSAs have been followed up.

LOCUM INDEMNITY COVER

You are acquainted with that lovely locum who does all your holiday cover, and has been coming for so long there is no need to check if they have valid insurance. No need, that is, until you realise that they have neglected to renew their Professional Indemnity cover, or as more frequently happens, they have insurance cover for four sessions a week, but are regularly undertaking nine sessions a week.

You are very exposed if there were to be a claim and your locum was uninsured while attending to your patients. You should therefore ask for up-to-date copies of all locums' medical insurance.

A reasonable practice management exercise is to have sight of all your practice assistants and partners' current medical insurance, for the same reason.

It is easy to check whether your locums and assistants are registered with the Medical Council and on the specialist register, so do ensure that you go online and check!

NEEDLESTICK INJURIES

Sharps and needlestick injuries are a potential hazard in all aspects of healthcare, and General Practice is no exception. An inadvertent needlestick injury in the practice, whether it involves cleaning staff, doctors, nurses, admin staff or patients, is a frightening experience and following the guidelines to manage the incident is time-consuming for all involved.

Medisec is aware that there has been a noticeable recent increase in sharps incidents, particularly in the Out of Hours setting. If you are involved in an Out of Hours cooperative, make sure that you are aware of the policy, and if you are not happy with the sharps management, say so.

Consider taking the time to examine your own sharps policies and possible sharps hazards by doing a walk through in your practice, or designate a staff member to do so, thus raising awareness for other members of the practice staff.

The HSE/HCAI document '*Infection Prevention and Control for Primary Care in Ireland – A Guide for General Practice*' provides useful guidelines and audit templates, and is freely available online.

You might consider completing the brief sharps audit contained in the document, which will only take ten minutes of your time. It includes the obvious risks such as sharps boxes in reach of children, not overfilling them, sealing them before disposal and needlestick injury management plans, as well as some more detailed safety points.

One of the key points in this document is "*Safe handling use and disposal of sharps is essential to prevent injury/ transmission of disease to patients, healthcare workers and cleaning staff. Each practice needs to have a policy in place for assessment and management of a needlestick injury. Education of all practice staff in sharps injuries prevention and management is essential*" (Chapter 7).

Many practices have a good sharps management system, but fail to have a needlestick injury policy. Even where there is a policy, sadly staff can be unaware of it. Therefore you should ensure that there is a policy and poster available for the management of sharps injuries and contamination incidents or injuries, and that all staff members are aware of it. You may be on holidays and have a locum in place when a critical sharps injury occurs, however the buck stops with you!

DEALING WITH FEVER IN YOUNG CHILDREN

"GPs are failing to carry out basic checks on children with a high temperature that could signal life-threatening illnesses such as sepsis, meningitis and pneumonia", a new, albeit small UK study indicates.

Guidance from the National Institute for Health and Care Excellence (NICE) says GPs must measure and record temperature, heart rate, respiratory rate and capillary refill time "as part of the routine assessment of a child with fever".

In the new study, Dr Alice Lee, from the Pennine Acute Hospitals NHS Trust, looked at data from 47 under-fives at a Stockport GP practice.

She found that just 13% of consultations included all four checks, with around one in three children receiving one or no tests at all. The failure of doctors to carry out all four checks had been implicated in several deaths in the UK.

While an ill child can without doubt deteriorate very quickly, occasionally with tragic consequences, the GP will be very well protected in a possible claim if they have recorded that these four checks have been carried out. Therefore GPs might consider creating a template in their practice software for the assessment of fever in young children, and to include these four parameters.

Current guidelines regarding management of fever in young children are easily accessible on the ICGP website under 'paediatric algorithms'.

TREATMENT
OF PATIENT RECORDS
ON THE TRANSFER OF GP PRACTICE

by Antonia Melvin,
O'Connor Solicitors,
Medisec Panel Solicitors

A GP's responsibility to patients' notes when transferring or taking over a practice.

The new Medical Council guidelines repeat the requirement for doctors to comply with data protection and other legislation, in relation to the storage, access and ultimate disposal of medical records. While GPs are well aware of the effect of these duties on a day-to-day basis in the management of their practices, the duties and obligations that must also be considered when either transferring or taking over a practice, due to retirement or some other reason, may not be so apparent.

For example, to ensure continuity of care on retirement, a GP should make arrangements for the transfer of his/her patients to another GP and in doing so arrange for the safe and secure transfer of the relevant patient records. Where GMS patients are concerned, the HSE will be involved in the allocation of the GMS list to another GMS GP to whom the records must automatically be transferred, or they may make other arrangements concerning the transfer of the GMS list.

Where private patients are concerned, GPs may need to discuss and negotiate with another GP as well as the patient themselves in relation to the transfer or takeover of their private patient list and the secure transfer and treatment of the relevant patient records, which may include old or archived documents. This is the case even if the same GP who is taking over the GMS list will also be taking over their private patients.

Patients should be notified of any retirement and/or proposed transfer in advance and private patients should be given an opportunity to consent to the transfer of their records or to request that their records be transferred to another GP of their choice. Time for this notification and transfer period should be factored into retirement plans.

As previously noted, GPs must be mindful that private patient records may contain archived or older records that are suitable for disposal. Data protection rules continue to apply to the treatment of these records and therefore arrangements must be made either for their disposal in accordance with data protection legislation as set out below, or for this responsibility to be taken over by the incoming GP.

In addition, older or archived records that are not being transferred, but which are also not yet suitable for disposal, should be either archived or securely stored in accordance with data protection rules until they are suitable for disposal as per the guidelines discussed below.

As a retiring GP transferring patients to a new GP, merely transferring the original records in their possession without retaining copies may appear a straightforward option. However a GP must be mindful that these records are the only means to justify and evidence their care delivery, professionalism and the fulfilment of their duties when faced with legal challenges and/or professional standard complaints, which can arise years after an event.

While retention of records may seem difficult, costly and cumbersome, though less so in relation to computerised records, if a copy is not retained - or the original having transferred a copy - GPs place themselves in a position where they will be reliant on the record keeping practices of a third party, over which they have no control, to defend themselves against a legal claim should it be necessary.

With this in mind, it is necessary that upon retirement, if they are unable to keep or archive a copy of their records, they retain a right of access to the original records if and when required. This may involve securing an undertaking with the new GP to this effect.

Likewise, it is extremely important if you are arranging to take over the practice of another GP, be it due to retirement, death or otherwise, to fully inform yourself of the situation relating to current or archived patient records and to negotiate clear terms as to who is responsible for the secure transfer, storage and, if appropriate, disposal of those records. Failure to deal with these issues clearly, in advance of taking over a practice, will likely result in a situation where you, as the GP taking over the patient lists, is deemed to have assumed responsibility for the entirety of the files of the practice. This includes all duties and obligations in relation to those records to include disposal where appropriate and the costs associated with that.

SECURITY OF TRANSFER

GPs should be mindful of security when transferring patient records by electronic means. Ensure that the records are sent by secure email to a secure email address such as HealthMail, or that the document is encrypted. Double-check the email address. Web-based email providers do not provide adequate security.

If a patient wishes to transfer to another GP, upon receipt of a request from the new GP with a signed consent of the patient, forward a complete copy of the patient's records while retaining the original for your own records. When posting copies of medical records, make sure they are marked 'Private and Confidential', use a sturdy sealed envelope, and send by registered post. Again, double-check the address.

Patients may prefer to collect a copy of their file and transfer it to their new GP themselves. In this case, the GP must review the file and carefully consider the obligation to remove all references to third parties and check there is nothing in the records which might cause harm to the patient were they to read it. This is particularly relevant where psychiatric records are included in the patient's file.

DUTIES ON DISPOSAL

Confidentiality obligations continue at time of disposal of records and they must be disposed of securely. Depending on the format of the record, this can mean physical destruction by shredding or incinerating, or in the case of electronic data, by permanently deleting the records from the hard drive and other storage devices.

Regardless of whatever format the disposal takes, GPs must ensure that it is completely, irreversibly and confidently destroyed. Particular care should be taken with regard to electronic devices that may be passed on for further use, to confirm that information is not recoverable by any means. This may require expert IT advice.

External contractors employed to carry out such disposal must be subject to strict contractual confidentially clauses and must be asked to certify that the data has been fully disposed of, appropriately and securely.

WHEN TO DISPOSE

The data protection rules state "information should not be retained any longer than is necessary for the purpose or purposes for which it was collected". The answer to 'how long is necessary?' in the context of medical records, is by no means clear-cut when both medical and legal criteria are considered. The new Medical Council Guidelines, paragraph 33.6, state, "you should keep medical records for as long as they are likely to be relevant to the patient's care, or for the time the law or practice standards require" and refers doctors to medical defence

organisations or legal advisers with regard to retaining records for medico-legal purposes. At present there are no national guidelines in place for General Practitioners, when it comes to the eventual disposal of medical records, however guidelines have been provided in the National Hospitals Office (NHO) Code of Practice for Healthcare Records Management published in 2007 – as outlined in the table below.

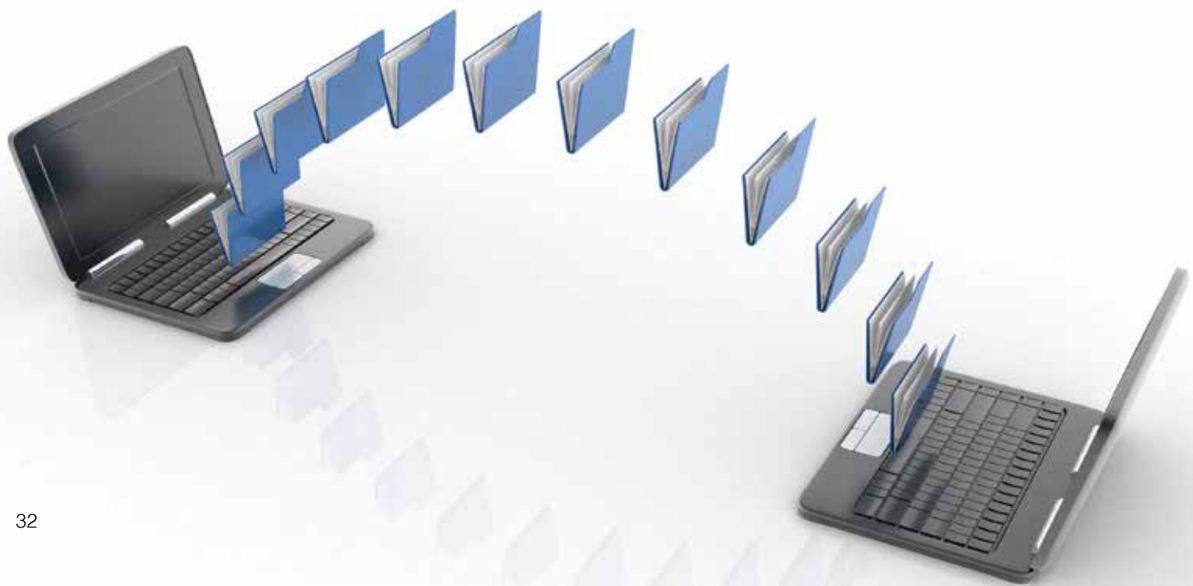
While the guidelines do give consideration to legal Statute of Limitation periods that limit the timeframes within which claims can be brought, the fact that these periods often do not start running until the date that an alleged negligence is discovered has seen many such cases taken up to 30 years after the incidents complained of have taken place. Indeed we recently dealt with a complaint to the Medical Council relating to events alleged to have occurred in 1978!

With this in mind we recommend that, when considering when to dispose of records or when GPs are developing practice retention policies, they can and should consider significantly longer minimum periods than those set out in the guidelines, in order to provide a more substantial protection against complaint or claims. Certain patients or categories of patients may also have particular factors that necessitate considerably more extensive periods and this should also be considered and set out in retention policies. Such policies should be subject to ongoing review.

There are always unusual and exceptional cases or situations where general advice will not be adequate and more specific advice must be sought. If in any doubt, members should seek advice from Medisec.

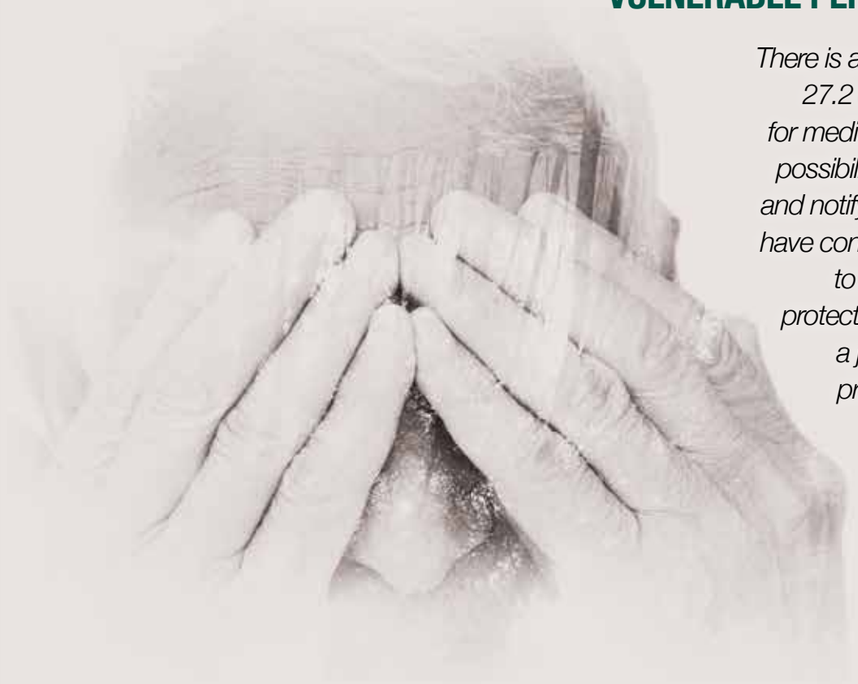
Part 5 Retention and Disposal Schedule: National Hospitals Office (NHO) Code of Practice for Healthcare Records Management, 2007.

TYPE OF PATIENT RECORD	TYPE OF PATIENT RECORD
Adult/General	8 years after last contact.
Deceased patients	8 years after date of death.
Children and young people	Retain until the patient's 25th birthday or 26th if young person was 17 at the conclusion of treatment, or eight years after death. If the illness or death had potential relevance to adult conditions or genetic implications, specific advice should be sought as to whether to retain the records for a longer period.
Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child.
Mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001)	20 years after the date of last contact between the patient and the doctor, or eight years after the death of the patient if sooner.
Patients included in clinical trials	20 years.
Suicide - notes of patients having committed suicide	10 years.
Cause of Death Certificate Counterfoils	2 years.
Records/documents related to any litigation	NHO recommend that the records are reviewed 10 years after the file is closed. Note however, if the litigation related to a child, this should not be used to lessen the retention period relating to Children and young people set out above.



SAFEGUARDING

VULNERABLE PERSONS AT RISK OF ABUSE



There is an ethical obligation under Section 27.2 of the Medical Council Guidelines for medical practitioners "to be alert to the possibility of abuse of vulnerable persons and notify the appropriate authorities if you have concerns. Giving relevant information to the appropriate authorities for the protection of others from serious harm is a justifiable breach of confidentiality, provided you follow the guidance in paragraph 31.2."

The HSE Policy for Safeguarding Vulnerable Persons at Risk of Abuse describes a vulnerable person as an adult who may be restricted in capacity to guard themselves against harm or exploitation, or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances.

It is known that older people and persons with disability can become vulnerable to abuse, even in settings which are intended to be places of care, safety and support.

WHAT IS ELDER ABUSE?

Elder abuse refers to abuse of a person age 65 or older and is defined as: "A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights" (Protecting Our Future – report of the Working Group on Elder Abuse, 2002).

TYPES OF ELDER ABUSE

Elder abuse can manifest itself in many different formats and may be the result of deliberate intent, negligence or ignorance. A person may experience more than one form of elder abuse simultaneously. Elder abuse can include physical abuse, psychological abuse, sexual abuse, financial abuse or neglect.

RECOGNISING ABUSE

As a mandated person, a GP must be aware of circumstances that may leave a vulnerable patient open to abuse and must be able to recognise the possible early signs of abuse. In this respect the GP should be alert to the demeanour and behaviour of older people who may be vulnerable and to the changes that may indicate that something is wrong.

CAPACITY

It is important that a vulnerable older patient is supported by you, as their GP, in making their own decisions about how they wish to deal with concerns or complaints.

Section 31.2 of the Medical Council Guidelines state that; "You should make every effort to involve vulnerable persons in decisions about their care. You should not assume they do not have the ability to consent". The vulnerable older patient should be assured that their wishes concerning a complaint will only be overridden if it is considered essential for their own safety or the safety of others or arising from legal responsibilities.

RECORDS

It is essential that the GP keeps detailed and accurate records of concerns or allegations of abuse of a patient and of any subsequent actions taken.

REPORTING CONCERNS

The HSE Policy for Safeguarding Vulnerable Persons at Risk of Abuse directs that The Safeguarding and Protection Team (Vulnerable Persons) be notified immediately of concerns and they will work in partnership with all relevant service providers to ensure that concerns and complaints are addressed swiftly. The HSE has a dedicated Elder Abuse Service, and their website states that they have Senior Case Workers in Elder Abuse working in most Local Health Office Areas. GPs can access a list of Senior Case Workers and their contact details on www.HSE.ie.

SUPPORT FOR THE PATIENT

A GP can also advise a patient to contact SAGE, the support and advocacy service for older people, which can be very helpful in providing support and advice for older persons. They can be contacted at **www.thirdageireland.ie/sage**

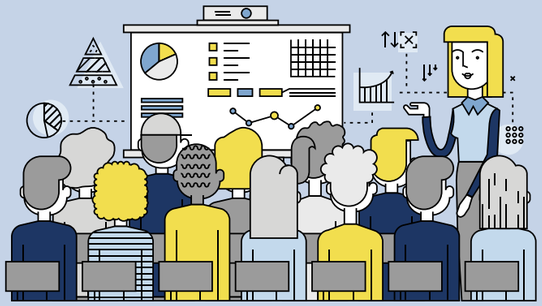
Ruth Shipsey is pictured with Dr Dermot Nolan, Dr Sharon O'Donnell and Dr Marion Ryan at the recent annual Waterford GP study day, where Ruth presented on the Medico-Legal Challenges of General Practice.

We are delighted to work closely with our stakeholders, GPs and staff to improve patient care and reduce risk. Whatever your requirements, we can tailor our workshops and talks for GP practices, trainee schemes and faculty meetings. Please contact Ruth at ruthshipsey@medisec.ie or by telephone 01 661 0504 to discuss how we can help your practice.

Aoife O'Higgins commenced employment with Medisec in June 2016 as a receptionist and PA to our CEO Ruth Shipsey. In 2014 she graduated from Trinity College Dublin with a BA (Hons) in Sociology and Social Policy. Aoife has a keen interest in the medico-legal advisory work undertaken by Medisec and will work with the team to develop her skills in this area.

CORONERS' INQUESTS TO BE ADDRESSED AT MEDICO-LEGAL SOCIETY ACADEMIC DAY

Medisec is delighted to be one of the sponsors of the Medico-Legal Society Academic Day conference on 4th February 2017. The conference, which is open to members and non-members of the Society, will cover The Coroner's Inquiry – Legislative and Procedural Reform with presentations, moot inquests and workshops which should be of interest to GPs. For more details contact **medicolegalsoc@gmail.com** or visit their website **www.medico-legalsociety.ie**



PHARMS

We are delighted to support and sponsor PHARMS (Patient Held Active Record of Medication Status), a feasibility study in Cork City which is assessing the introduction of a patient-held electronic medication record at the interface of primary and secondary care, with the aim of reducing the occurrence of medication error.

Collaborative work was conducted in UCC between the Department of General Practice, with the involvement of Professors Colin Bradley and Henry Smithson, and the departments of Technology Transfer, Data Analytics and Health Information Research. The group worked with Si Key Ltd, a commercial GP software provider, to produce and develop an electronic patient-held medication record. Phase 1 involved a successful exploration of the usefulness and acceptability of the device to key stakeholders, and collection of data on the occurrence of medication error. The findings are now being used to inform the development of Phase 2 of the study.

We acknowledge the potential benefits widespread use of such a device will bring, both for patient safety and the reduction of medication error within general practice, and we will let you know the results of the study once they are published.

IRISH MEDICAL FOOTBALL TEAM

As proud sponsors of the Irish Medical Football Team, we'd like to congratulate the team for putting in such an impressive performance at July's World Medical Football Championships in Barcelona, raising much-needed funds and awareness for their charity partner Pieta House.